

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER: 235518	(X2) MULTIPLE CONSTRUCTION A. Building B. Wing	(X3) DATE SURVEY COMPLETED 04/08/2026
NAME OF PROVIDER OR SUPPLIER Maple Woods Manor		STREET ADDRESS, CITY, STATE, ZIP CODE 13137 North Clio Road Clio, MI 48420	

For information on the nursing home's plan to correct this deficiency, please contact the nursing home or the state survey agency.

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (Each deficiency must be preceded by full regulatory or LSC identifying information)
F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>Protect each resident from all types of abuse such as physical, mental, sexual abuse, physical punishment, and neglect by anybody.</p> <p>**NOTE- TERMS IN BRACKETS HAVE BEEN EDITED TO PROTECT CONFIDENTIALITY** This citation pertains to Intake Numbers 2685912 and 2701537. Based on interview and record review the facility failed to protect one resident's (Resident #302) right to be free from neglect, resulting in 1. Significant delay in the administration of enteral nutrition and hydration; 2. Discharge medication orders (insulin and tube feed formula) were not followed without a rationale; 3. Untimely intervention for persistently elevated blood glucose levels and lack of communication to the practitioner; and 4. An ongoing respiratory assessment and monitoring of an acute infection with antibiotic administration, which led to an unnoticed change in condition requiring hospitalization. Findings Include: On [DATE] at approximately 2:30 PM, a review was conducted of Resident #302's medical records and it revealed he was admitted to the facility on [DATE] at approximately 6:30 PM with diagnoses that included, Cerebral Infarction, Pneumonia, Dysphagia, Type 2 Diabetes. Further review of the record yielded the following: Hospital Discharge Records [DATE]: Diet currently NPO (nothing by mouth) due to severe oropharyngeal dysphagia. requires PEG tube feeding (Glucerna 1.5 cal (calories), 60 mL (milliliter) /hr (hour) goal rate, 1440 mL, 2160 kcals (kilocalories). Medication management. diabetes (insulin lispro.) During the hospital course (Resident #302) exhibited altered mental status, described as lethargic, drowsy, unresponsive and nonverbal. the cognitive and behavioral state is likely related to his acute ischemic multifocal posterior circulation stroke. Diagnosis. Type 2 diabetes mellitus. Discharge Diagnosis List. Diabetes. admission Assessment [DATE]: .confused, short-term memory problem, long-term memory problem. blood sugar 216. DM (diabetes mellitus) .resident is very confused and can be combative at times, does not understand that he has a rm mate and thinks someone is taking his money. Care Plan: .Report hyperglycemia signs and symptoms to supervising nurse. Obtain diagnostics tests/labs per health care practitioner order. On [DATE] at approximately 2:00 PM, the DON (Director of Nursing) and Corporate Consultant T stated there are batch orders embedded into their electronic medical system for enteral nutritional and the nurse would then need to tailor the specifics of the order to the resident. A review was conducted on Resident #302's hospital discharge records and MAR (Medication Administration Record). The discharge records indicated the following: Insulin lispro (insulin lispro 100 units/mL (milliliter) injectable solution) Dose: 0-18 unit subcutaneous four times a day with meals and at bedtime. There was a handwritten note by facility staff by the order, placed note in Dr (doctor) book for clarification on [DATE]. Glucerna 1.5 cal, 60 mL/hr (hour) goal rate, 1440 mL, 2160 kcals, 119 g (grams) protein, 1093 mL FW (free water). estimated fluid needs: 2254-2454 mL/day. Upon admission the facility switched his enteral nutrition to Jevity 1.5 (rather than the Glucerna that was listed in his discharge orders) and he was not administered his enteral nutrition until [DATE] around 2:00 PM (according to the MAR). Furthermore, his insulin was not ordered and administered by the facility until [DATE]. The DON was asked for rationale for the above- he reported he would investigate the above and follow up. On [DATE] at 5:00 PM, Nurse O reported Resident #302 was a two person assist and strictly NPO (nothing by mouth). His wife was very in tune with his needs and would typically alert her if he was in pain or anything out of the ordinary. Nurse O was asked what were the blood sugars parameters when they needed to contact their practitioners and (continued on next page)</p>

Any deficiency statement ending with an asterisk (*) denotes a deficiency which the institution may be excused from correcting providing it is determined that other safeguards provide sufficient protection to the patients. (See instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE	TITLE	(X6) DATE
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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>she stated anything above 400 they would typically contact the physician for further direction. On [DATE] at 9:11 AM, Complainant D reported upon Resident #302 arriving at the facility it appeared they did not have any of his discharge information and they had to contact the medical floor at the hospital to provide information regarding Resident #302's enteral nutrition rate. Earlier in the week prior to him being transferred to hospital he appeared to be at his baseline but as the week progressed he declined. He was in bed, asleep and difficult to arouse. The day he was transferred to the emergency room he was asleep with the fan blowing on his face and upon getting closer there was sweat beating down his face. The nurse assigned made the excuse that she only comes every week or so and was not familiar with the resident. The complainant stated Resident #302 had been like this for a few days with no interventions from the facility and he passed away a week later in the hospital. On [DATE] at approximately 9:30 AM, the DON reported he spoke to their Nurse Practitioner regarding Resident 302's insulin order. After the practitioner reviewed the chart and spoke to the resident (the day after admission -[DATE]) it was found the resident was not on a home insulin regime prior to admission to the hospital. They entered an order to check Resident #302's blood sugars on [DATE] but it did not pull over to the MAR. This error was rectified on [DATE]. The DON was asked if there were any notes detailing the discussion the Nurse Practitioner had with Resident #302. The DON stated it was not explained fully in his documentation why the insulin was not reordered. On [DATE] a Care Conference was held for Resident #302 and the document stated Severely cognitively impaired. It is unknown how the resident would be able to provide medical history regarding medications to the facility practitioner. Resident #302's medication order dates and time of administration were reviewed: [DATE] MAR (Medication Record): Medication Orders: Jardiance Oral Tablet 25 MG- for Type 2 Diabetes Mellitus. Started on [DATE] (13 days after admission). Lantus Solostar 100 Unit/ML solution pen injector- inject 20 units subcutaneously at bedtime for Type 2 Diabetes Mellitus. Started on [DATE] (14 days after admission). Amoxicillin-Pot Clavulanate Oral Tablet for infection. Started on [DATE] and completed on [DATE]. Enteral Feed Orders: Enteral Feed Order: every 4 hours for Tube Feeding Tap water flush- 150 volume to be flushed in 24 hours- 600 cc per day of free water for medication pass. First administered on [DATE] at midnight. Enteral Feed Order: Jevity 1.5 at 65/ml per hour for a total of 1560 cc infuses in 24 hours. First administered on [DATE] at 2 PM (evening). Enteral Feed Order: Glucerna 1.5 at 65/ml per hour for a total of 1560 cc infused in 24 hours. Started on [DATE]. It can be noted Glucerna was listed on Resident #302's diet order upon admission to the facility. Medication Audit Report: Enteral Feed Order: every 4 hours for Tube Feeding Tap Water Flush First administrated on [DATE] at 1:00 AM (this was approximately 6 hours after admission to the facility). Enteral Feed Order every shift for Tube Feeding- Jevity 1.5 at 65/ml per hour First administered on [DATE] at 17:10 (approximately 23 hours after admission to the facility). On [DATE] at 10:35 AM, an interview was conducted with Physical Therapy Assistant (PTA) E. He reported he worked with Resident #302 on strengthening, balancing and safe transferring. He first worked with the resident on [DATE] and he initially seemed to be making progress as he was walking about 20 feet and at one point close to 100 feet. But prior to his discharge to the hospital, he was going backwards. He had a posterior lean and his transfers were becoming more difficult. Resident last days of therapy were [DATE] and [DATE] and those were difficult days for him. He was total for transfer and max assist of two. He appeared to show physical decline, seemed lethargic and did not appear to be at his baseline toward the end of his stay. On [DATE] at 1:50 PM, an interview was conducted with Speech Therapist F regarding her work with Resident #302. Therapist F reported he was NPO with a PEG (Percutaneous Endoscopic Gastronomy tube) and she was working on swallowing, cognition and language. He could not articulate what he wanted but his wife was there and able to assist in goal setting. He recalls him having flat affect and responded with expression level words and at time phrases. On [DATE] she wrote that the PTA stated Resident #302 was attempting to eat a weight and when she assessed him, he stated he indicated he had pain in his mouth. Therapist F observed a white coating on his tongue and informed (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>the nurse regarding it who stated that he was something refused the spray that assisted. She reported all the appropriate individuals were informed of his change in condition. Review was conducted of Resident #302's therapy documentation:Physical Therapy:[DATE]: .Patient has had physical decline this week with increased lethargy. Nursing has been made aware.Speech Therapy:[DATE]: Patient's PTA reported that the patient was attempting to eat a weight.SLP (speech therapist) alerted rehab manager who spoke with clinical care coordinator and NP as well due to concern for change in status reported by PTA. On [DATE] at 2:40 PM, an interview was conducted with CNA (Certified Nursing Assistant) G regarding Resident #302. The CNA stated she recalled him being a hoier lift and mumbling when he talked. Shortly before he was sent out to the hospital, they were assisting with getting him up and he became dizzy, seemed increasingly tired and appeared like he was going to pass out. He was not sitting up correctly in his wheelchair and slumped forward some. Soon after this occurred, he was transferred to the hospital for evaluation. On [DATE] at 1:00 PM, CNA H reported upon admission Resident #302 was a hoier lift and then two persons assist. Toward the end of his stay he began to decline and transferring him became increasingly difficult as he was dead weight. But at the beginning of his stay, he would assist with the transfers. On [DATE] at 2:40 PM, an interview was conducted with Nurse C regarding Resident #302. Nurse C reported she was the nurse that completed his admission and that note regarding the insulin was due to the hospital not providing the sliding scale parameters. She recalled asking the oncoming nurse to contact the doctor for clarity regarding the order. Nurse C stated she did check his blood sugar, and it was not alarming at 216. They contact the physician when levels are 300 and above. During his stay she was alerting the practitioners that his blood sugars were high.Review was conducted of Resident #302's Progress Notes:Progress Notes:[DATE] at 14:48: This A.M. his BS (blood sugar) was 510. Order was obtained to give 20 units of regular insulin. At noon his BS was 449. His wife was here to visit at 1330. She wanted resident to be sent to (Emergency Room). She stated she noted a change in condition on Wednesday. He was seen by the NP on Friday. Labs ordered for tomorrow. at 1413 report called to nurse.Ambulance arrived and transported resident to hospital. [DATE] at 01:00: (Resident #302) was seen today for PT (Physical Therapy) reported he has increased fatigue and weakness. Patient stated he has not been sleeping very good and he is tired. Blood sugars have been increased and are being monitored.Labs ordered. [DATE] at 01:00: (Resident #302) was seen today for Acc checks. Nursing came to me today. He had a blood sugar this morning of 435. He is not on medications for diabetes.Past medical history. type 2 diabetes mellitus.unable to obtain ROS due to confusion.Start Jardiance. Cont (continue) to monitor checks accuchekcs. A1C.XXX[DATE] at 01:00: .Check accuchekcs, A1C XXX[DATE] at 01:00: .pt (patient) confused this am gives different answers than yesterday. told me he was living on the street, single.thinks its is [DATE].Type 2 diabetes mellitus without complication, unspecified whether long term insulin use.check accuchekcs, A1C. [DATE] at 01:00: .Type 2 diabetes mellitus without complication, unspecified whether long term insulin use: currently no meds, check labs with A1C. There was no documentation located regarding the following:Nursing assessment regarding his change in condition or transfer forms.Antibiotic use for diagnosis of pneumoniaRespiratory assessments/ monitoring for progressing or improvement of pneumonia.Assessment/monitoring of PEG tube site.Notification to physicians regarding the numerous elevated blood sugar levelsA1C lab results as requested by the physician.Delay in providing enteral nutrition and hydration Review was conducted of Resident #302's Blood Sugar's from 9-8-25 to 9-21-25. The 29 times that Resident #302's blood sugars were above 300. It can be noted there was a delay in facility intervention to address his consistently high and unmanaged blood sugar levels and it was unknown who was monitoring the levels closely:[DATE] at 16:54: 333XXX[DATE] at 15:30: 308XXX[DATE] at 11:38: 332XXX[DATE] at 15:40: 334XXX[DATE] at 08:16: 329XXX[DATE] at 08:20: 309XXX[DATE] at 10:27: 315XXX[DATE] at 11:41: 341XXX[DATE] at 16:05: 300XXX[DATE] at 10:06: 435XXX[DATE] at 12:44: 455XXX[DATE] at 16:52: 385XXX[DATE] at 07:33: 409XXX[DATE] at 11:09: 419XXX[DATE] at 16:02: 383XXX[DATE] at 08:55: 304XXX[DATE] at 11:48: (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>333XXX[DATE] at 17:10: 359XXX[DATE] at 07:00: 315XXX[DATE] at 11:48: 339XXX[DATE] at 15:55: 315XXX[DATE] at 14:55: 301XXX[DATE] at 16:47: 386XXX[DATE] at 07:32: 378XXX[DATE] at 12:59: 406XXX[DATE] at 16:15: 392XXX[DATE] at 20:59: 386XXX[DATE] at 08:06: 510XXX[DATE] at 11:35: 449.0 On [DATE] at 1:50 PM and 4:18 PM phone contact was attempted with Nurse L regarding Resident #302. Nurse L was the nurse assigned to care for the resident the day he was transferred to hospital. There was no answer and voicemail was left. On [DATE] at 3:00 PM, an interview was conducted with CNA M regarding Resident #302. CNA M recalled the resident initially being a hooyer lift and then a two-person assist. Around the week of his discharge, he became increasingly weak and it was difficult to complete a transfer with just two people as he was dead weight. She stated he appeared to be more lethargic and unable to assist them with dressing/undressing or his transfers. EMS (Emergency Medical Services) Run Report [DATE]: .Call received on [DATE] at 14:06 and unit on scene at 14:18. dispatched to the above nursing home with lights and sirens for AMS (altered mental status). Upon EMS arrival the patient was lying in bed, diaphoretic, responsive to pain only, and an irregular breathing pattern. Staff stated that he has been like this for 4 days and has had a BGL sustained above 500 for those 4 days . He was assessed further and he was hyperglycemic and tachycardic. Wife states that he had 2 strokes within the last year leaving him with cognitive deficits and that hes usually AOX1 and talkative.He was placed on oxygen due to his irregular breathing pattern. An IV was attempted but he would pull away and flail his arm with each IV attempt.blood sugar 589. Hospital Records:admitted on [DATE]- [DATE] .Normally AO1 (alert and oriented x1) and talkative, now not speaking, breathing heavily. Sugar has been over 500 for last four days.according to EMS, patient has been persistently hyperglycemic over the course of the last 3 days.Ataxic breathing noted.who was admitted with altered mental status hypernatremia, hyperglycemia, and sepsis. On admission, he was found to be obtunded, febrile, tachypneic, and found to have severe hypernatremia with serum sodium of 168, Hyperglycemia (glucose >400), acute kidney injury (Cr peaked at 4.4), and E. coli bacteremia likely secondary to a urinary source (UA with pyuria, blood cultures positive for E. coli). Patients was also noted to have elevated troponins. Infectious Disease was consulted for management of E. coli bacteremia and recommended continuing IV cefepime and metronidazole. Hospice team was consulted. Patient placed on morphine drip and admitted to inpatient hospice for continued comfort care. Eventually patient expired on [DATE] at 1910. Called to see patient for unresponsiveness. On exam the patient did not respond to verbal or physical stimuli. Absent heart and breath sounds for over 1 minute. Absent peripheral pulses. Pupils are fixed and dilated; absent corneal reflex. Patient pronounced dead at 1910 on [DATE]. On [DATE] at 4:55 PM, an interview was conducted with the DON and Administrator regarding Resident #302. The DON explained on admission the nurse assigned to the resident inputs the medications into the system, it is verified by a 2nd nurse (typically their hall partner) and the 3rd check is the next shift or the Clinical Care Coordinator.The DON was asked to clarify what occurred with Resident #302's missed insulin order. He stated the practitioners spoke to the residents and he was not on insulin at home which is why the order was not followed. He continued they began an oral diabetic medication on [DATE] and Lantus on [DATE] with notification to the practitioners on [DATE] regarding the increased glucose levels. A review of Resident #302's blood sugars and they were over 300 ten times ([DATE]-[DATE]) without intervention by the facility. The facility was unable provide any other interventions implemented.The DON stated after their review they were unable to ascertain why Resident #302 was ordered Jevity versus Glucerna (listed on discharge medication list). It can be noted Glucerna is enteral nutrition formulated for patients with diabetes. The DON was asked if a 24- and 12-hour delay, respectively is satisfactory for enteral nutrition residents to be administer their tube feeding formula and hydration. The Administrator reported it should not have taken that long for the resident to be administered his tube feeding. The DON was uncertain as to why this occurred as there was no documentation related to the delay. The DON was asked if a resident is admitted on an antibiotic for pneumonia what would their assessment and monitoring of the resident entail. He stated (continued on next page)</p>		

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F 0600 Level of Harm - Actual harm Residents Affected - Few	<p>there would be a handwritten short term care plan related to the antibiotic and diagnosis. Nurses would complete respiratory assessments that would include vitals, lung sounds, depths, and efforts. The assessment could be tied to the MAR or a separate progress note. He was asked to review Resident #302's record to find any documentation regarding his admitting diagnosis of pneumonia and antibiotic usage. The DON was unable to find any assessments, monitoring, short-term care plan or mention of the resident and his admitting diagnosis of pneumonia with antibiotic usage. The DON reported he was unsure as to how this was missed. The DON was queried if the PEG tube site is assessed for residents. The DON stated it is and there is an order that is inputted to prompt nurses to complete it. The DON was queried if there was any assessment documentation for the skin integrity, placement, etc. the DON reviewed Resident #302's record and was unable to locate any documentation regarding his site. Review was conducted of the facility procedure entitled, Standing Orders, reviewed [DATE]. The procedure stated, Hypoglycemia/Hyperglycemia. If blood Sugar > 400 Notify the Nurse Practitioner / Physician. Review was conducted of the facility policy entitled Assessment & Management of Diabetes, revised [DATE]. The policy stated, . To systematically manage and improve the care of residents with diabetes. To promote evidenced-based management of individuals with diabetes. Complete the nursing admission, medication review, laboratory testing as ordered, in addition to ordered blood sugars, finger-stick testing may be completed as a nursing judgement as indicated, communicating results to the health care practitioner as indicated. Review was conducted of the facility policy entitled, Interdisciplinary Documentation and admission Assessments, revised [DATE]. The policy stated, .Documentation: used in this reference to mean any written or electronically generated information about a resident that describes care or services provided. The medical record reflects assessment facts and other information relative to the course of treatment provided.</p>		